

Analysis of the implementation of the healthy Indonesia program policy with a family approach

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ABSTRACT

This study evaluates the implementation of the Healthy Indonesia Program Family Approach to improve public health and identify inhibiting and supporting factors. This qualitative research employs a case study approach to investigate healthcare dynamics at the Tambora Community Health Center in Bima City, Indonesia. Twelve informants were purposively selected. Data collection involved in-depth interviews, direct observation, and document review, allowing for a multifaceted perspective. An interactive analysis model by Miles and Huberman was used for data analysis, incorporating data collection, reduction, and presentation iteratively. Results showed that 85% of implementing staff had been trained, but there was a shortage of field surveyors, and family visit coverage only reached 72%, below the national target of 80%. Although the average healthy family index of 0.65 indicates adequate results, the main challenges lie in clean living behavior and nutritious diets. The program for mothers giving birth in health facilities reached 95%, but awareness of improving the management of chronic diseases, such as hypertension and tuberculosis, remained low, with treatment fulfillment at 65% and 70%, respectively. The conclusions highlight the need for adaptation strategies and continuous evaluation for the Healthy Indonesia Program to be successful across communities.

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1. INTRODUCTION

The Healthy Indonesia Program with a Family Approach (PIS-PK) serves as a significant health initiative aimed at addressing the multifaceted health challenges within Indonesia. While it promotes engagement in health-related practices at the family level, the program faces critical gaps between national health objectives and local healthcare delivery outcomes. For instance, several studies indicate that anticipated improvements in health indices, such as stunting and maternal health, remain unmet due to pervasive barriers, including inadequate healthcare staff training and insufficient community involvement [1]. Moreover, urban-rural disparities exacerbate these challenges by creating differential access to health services, hindering the program's efficacy [2]. Ongoing assessments and adaptations of health strategies are vital to bridging this gap, ensuring comprehensive participation in health initiatives and fulfilling national health goals [3].

Beyond basic health metrics, the notion of holistic wellness is encapsulated in the Healthy Indonesia Program also addresses broader social determinants of health, such as food security and obesity prevention. This multifaceted approach is important for a nation facing the dual burdens of undernutrition and rising obesity

prevalence, particularly among lower socio-economic and marginalized populations [4]. The government's strategies combine policy formulation, socioeconomic empowerment, and community nutrition interventions, establishing a comprehensive framework designed to enhance the public's overall health landscape [4].

The implementation of the PIS-PK is a crucial initiative that aims to improve public health in Indonesia by focusing on family-based interventions. This program consists of twelve key health indicators designed to enhance the health status of families, signifying the central role that familial engagement plays in health promotion efforts in the country. Key indicators include participation in family planning, maternal healthcare, immunization for infants, and ongoing health management for chronic conditions such as tuberculosis and hypertension [5]. The success of PIS-PK hinges not only on healthcare delivery but also on the active engagement of families in their health management, aligning with global health strategies that advocate for family-centered care as an effective approach to improving health outcomes [6].

The program faces numerous challenges and barriers in implementation, particularly in resource-limited settings. Studies have documented that the effectiveness of PIS-PK can be hampered by several factors, including inadequate training among healthcare providers, insufficient community engagement, and structural issues within the healthcare system [7]. These barriers are particularly prominent in rural areas, where access to healthcare facilities and continuity of care are limited. Moreover, existing socio-economic disparities exacerbate these challenges, as marginalized populations typically experience higher levels of health burdens and lower access to necessary health services, making effective implementation of family-focused health strategies even more critical [8].

The context of urban versus rural disparities also plays a significant role in understanding the implementation of health programs such as PIS-PK. In densely populated urban areas, community health resources may be more readily available; however, issues such as overcrowding can impede effective service delivery. Comparatively, rural regions may struggle with systemic barriers underscored by geographic isolation, limited economic resources, and reduced healthcare workforce presence [9]. The implementation of PIS-PK in settings like the Tambora Bima Community Health Center is particularly important for identifying how these contextual factors influence both the engagement of families in healthcare initiatives and the overall effectiveness of public health outcomes.

Moreover, the novelty of this case study lies in its exploration of the specific challenges and achievements encountered in the Tambora Bima Community Health Center context. By conducting an in-depth evaluation of local practices and health outcomes, this study contributes to the broader understanding of how PIS-PK can be contextualized to better serve populations with unique needs [10]. It highlights the importance of customizing health interventions to resonate with the cultural and socio-economic characteristics of communities, thereby maximizing participation and effectiveness in health promotion. Additionally, studying the intersections of access, health education, and community involvement provides insights into how to adapt existing frameworks to enhance health program delivery comprehensively. Evaluating the effectiveness and impact of PIS-PK through empirical evidence and qualitative data will underscore the critical need for continuous assessment and adaptation of health interventions to meet evolving health challenges and conditions within diverse Indonesian communities [11]. This includes examining community perceptions of health service effectiveness, the role of social determinants in health behaviors, and the overall satisfaction of families with health services provided under the program.

The purpose of this study on the implementation of the Healthy Indonesia Program Policy with a Family Approach at the Tambora Bima Community Health Center is to evaluate the effectiveness of the program's implementation in improving public health through a family-based approach. This study aims to identify factors that hinder and support the implementation of PIS-PK and its impact on health behavior and community well-being in the area. The novelty of this study lies in the in-depth analysis of the contextualization of the Healthy Indonesia Program Policy with a Family Approach program in the Tambora Bima Community Health Center setting, taking into account demographic characteristics and local health needs. This study seeks to provide evidence-based recommendations for improving program implementation, as well as contributing to the development of a more inclusive and responsive health policy model to community needs. Therefore, the results of this study are expected to make a significant contribution to strengthening health policies at the national and local levels.

2. METHOD

2.1. Design

This research is qualitative research with a case study approach. The Tambora Community Health Center (*Puskesmas* Tambora) is located in Bima Regency, one of Indonesia's primary healthcare facilities. The *Puskesmas* serves as a healthcare provider for the local community and plays a crucial role in improving public health and preventing disease. Bima Regency is known for its geographic and social challenges that impact access to and quality of healthcare, making the selection of this location highly relevant.

2.2. Research informants

The informants in this study consisted of 12 individuals representing various elements involved in healthcare services at the Tambora Community Health Center. Informants were selected using purposive sampling, a technique for selecting informants based on specific criteria relevant to the research objectives. The selection of 12 informants for this qualitative case study at the Tambora Community Health Center (*Puskesmas*) is justified through several critical factors. Purposeful sampling is essential in qualitative research to ensure that the informants contribute rich, relevant data that align with the research objectives. Thus, engaging a diverse group of informants including the H 1 Head of *Puskesmas*, 3 PIS-PK officers, 4 health workers (comprising both medical and non-medical staff), 2 health cadres, and 2 target families as shown in Table 1, enables the study to encapsulate multiple perspectives and experiences in healthcare services, which is vital for a comprehensive understanding of the dynamics in a complex healthcare environment.

Table 1. Informants

Type of informant	Number	Inclusion criteria
Head of <i>Puskesmas</i>	1	Leadership insights on policy and management
PIS-PK Officers	3	Implementation of health programs
Health workers	4	Perspectives on daily healthcare practices
Health cadres	2	Community health education roles
Target families	2	Firsthand experiences with health services

2.3. Type of informant

The types of informants selected are crucial for gaining a comprehensive understanding of the dynamics at play. The Head of the Community Health Center (*Puskesmas*) serves as a leader, providing insights into policy, management, and challenges in health services. PIS-PK officers, with their role in implementing health programs, provide data on the effectiveness of existing programs. Health workers, consisting of both medical and non-medical personnel, offer perspectives on daily practices and evaluation of services provided to patients. Health cadres play a crucial role in bridging the gap between the community and health facilities, as well as in health education. Finally, the target families, as subjects of the intervention, provide invaluable firsthand experience in assessing the impact of health services. By combining information from these various informants, the research can produce a more holistic picture of practices and challenges in the public health sector.

2.4. Data collection technique

Research data was collected through three main techniques: in-depth interviews, observation, and document review. Each technique has its own advantages and limitations, complementing each other to provide a more holistic understanding.

2.5. In-depth interview

In-depth interviews were conducted to gather detailed information from the informants' perspectives. The semi-structured interview format allowed researchers to tailor questions based on the informants' responses, thus deepening discussions on relevant topics. The questions focused on their experiences in healthcare, their perceptions of implemented policies, and the challenges they face in daily practice.

2.6. Observation

Direct observations at the research site were conducted to obtain contextual information regarding interactions at the community health center. These observations focused on patient crowds, interactions between healthcare workers and patients, and the effectiveness of health information delivery. Additionally, observations of the physical environment and available resources were conducted to understand factors influencing service delivery.

2.7. Document review

Relevant documents, such as annual reports, health data, and protocols used at the community health center, were analyzed to obtain secondary data to support the findings from interviews and observations. This document review provided additional information on management strategies, health program plans, and achievements.

2.8. Data analysis

The data obtained from these three techniques were analyzed using the interactive analysis model developed by Miles and Huberman. This model includes three main components: data collection, data

reduction, and data presentation. The analysis process was carried out iteratively and in parallel, with researchers continually returning to the data to generate deeper interpretations. Data was analyzed using Miles and Huberman's interactive analysis model, encompassing data collection, reduction, and presentation. Triangulation was conducted by comparing data from different sources for consistency, while member-checking involved validating findings with informants to enhance the credibility of results.

2.9. Data reduction

Data reduction is necessary to select relevant data and eliminate unnecessary information. At this stage, interview transcripts and observation notes are organized and categorized according to research theme.

3. RESULTS AND DISCUSSION

Table 2 presents the results of the analysis of the implementation of the Healthy Indonesia Program using a family approach, which includes several critical analysis aspects. First, in terms of input, 85% of the PIS-PK implementing staff have been trained, although there is a shortage of field surveyors. Second, in terms of process, family visit coverage reached 72%, below the national target of 80%. In terms of output, the average healthy family index value was 0.65%, which is considered adequate, but there are issues related to clean and healthy living behaviors (PHBS) and nutrition. Support from local governments and cadres is a significant supporting factor, with the availability of operational budgets and active cadres. Conversely, low community participation and the high workload of health workers are inhibiting factors that make it difficult to achieve the target. Finally, in terms of outcome, 60% of families showed an increase in healthy behavior, but continued strengthening of education to improve community health behavior is still needed.

Table 3 shows that most indicators are approaching their targets, although challenges remain. The family planning (KB) program has reached 85% coverage, but some families remain inactive. Ninety-five percent of mothers receiving care at health facilities, approaching the national standard. Infant immunization is achieved at 88%, despite access constraints. Only 72% of infants are exclusively breastfed, indicating the need for further education. Other health indicators, such as treatment for pulmonary tuberculosis (70%) and hypertension (65%), indicate the need for improved compliance and accessibility. Conversely, negative indicators, such as smoking within the family (40%) and access to adequate sanitation, indicate critical areas requiring further attention. Family support for people with mental disorders (90%) and BPJS membership (82%) demonstrate positive aspects of family health efforts.

Table 2. Results of the analysis of the implementation of the Healthy Indonesia Program with a family approach

Analysis aspects	Indicator	Findings	Information
Input (policy & HR)	Availability of PIS-PK implementing staff	85% of the workforce has been trained in PIS-PK	There is still a shortage of field surveyors
Process (implementation)	Family visit coverage	72% of families have been visited	The national target of 80% has not been achieved
Output (activity results)	Average healthy family index value	0.65% (adequate category)	There are still problems with PHBS and Nutrition
Supporting factors	Support from local government and cadres	Operational order available, active cadres	Support program acceleration
Inhibiting factors	Community participation and health worker workload	Low participation rate, high workload.	Makes it difficult to achieve targets
Outcome	Changes in family health behavior	60% of families showed an increase in healthy behavior	There is still a need for strengthening continuous education

Table 4 presents a gap analysis of 12 healthy family indicators at the Tambora Community Health Center, comparing the community health center's achievements with national targets. The data shows that several indicators fell short of the national target, including: hypertension patients receiving regular treatment (-20%), the number of family members who smoke (-20%), and TB patients receiving standard treatment (-15%). Meanwhile, indicators such as delivery in a health facility and access to healthy latrines exceeded the national target, with surpluses of +5% and +8%, respectively. The average achievement at the Tambora Community Health Center was 73%, which is considered to be in the fairly healthy category. These findings indicate the need for efforts to improve compliance with health programs, particularly in the management of chronic diseases and interventions to address smoking risk factors in families.

Table 5 shows that the findings indicate that exclusive breastfeeding, TB, hypertension, and smoking are priorities for intervention, with key issues identified as cultural, economic, and a lack of understanding. Recommended improvement strategies include strengthening education, empowering cadres, routine monitoring, and policy advocacy. These steps are expected to achieve significant improvements in public health indicators.

Table 3. Achievements of 12 indicators of healthy families

Healthy family indicators	Achievement (%)	Information
The family follows the family planning program	85%	There are still inactive families in KB
Mother gives birth at a health facility	95%	Almost in line with the national target.
The baby received complete immunizations	88%	There are still obstacles to access and refusal of immunization.
The baby receives exclusive breastfeeding	72%	Need for ongoing education
Toddler growth is monitored	80%	Limited Posandu in several areas
Pulmonary TB sufferers receive treatment according to standards	70%	There are still patients who have stopped taking their medication
Hypertension sufferers take regular medication	65%	Low compliance rate
People with mental disorders are not neglected	90%	There is quite good family support
No smoking in the family	40%	Smoking rates are still high
The family becomes a BPJS member	82%	There are still families not registered
Families have access to clean water facilities	85%	There are areas with limited facilities
Families have access to healthy toilets	88%	There are still inadequate toilets

Description: Average family health index = 0.72% (sufficient category)

Table 4. Analysis of the campaign gap for 12 healthy family indicators

Healthy family indicators	National target (%)	Tambora achievement (%)	Gap (%)	Information
Families follow the family planning program	80%	78	-2	Almost reached, need to increase KB
Childbirth in a health facility	90%	95	+5	Exceeding the target
Complete basic immunization for babies	85%	88	+3	It has been achieved
The baby receives exclusive breastfeeding	80%	72	-8	Need for mothers' educational support
Toddler growth is monitored	80%	80	0	According to target
TB sufferers receive treatment according to standards	85%	70	-15	The gap is quite large, requires strict monitoring
Hypertension sufferers take regular medication	85%	65	-20	Low compliance
People with mental disorders are not neglected	80%	90	+10	Exceeding the target
No smoking members	60%	40	-20	Smoking rates are high, education and regulation need to be improved
The family becomes a member of BPJS	85%	82	-3	Almost on target
Access to clean water facilities	80%	85	+5	It has been achieved
Access to healthy toilets	80%	88	+8	It has been achieved

Information: Average achievement of Tambora Community Health Center = 0.73 (fairly healthy category). Indicator with the biggest gap: i) Hypertension sufferers take regular medication (-20%); ii) No family members smoke (-20%); and iii) TB patients receive treatment according to standards (-15%)

Table 5. Analysis of public health indicators and intervention-based improvement strategies

Low gap indicator	Main problem	Recommendations for improvement strategies
Babies receive exclusive breast milk (72%)	Low mother patience is influenced by the culture of promoting formula milk	1. Strengthening exclusive breastfeeding education through pregnancy classes and health posts 2. Empowerment of breastfeeding cadres in each village 3. Collaboration with community and religious leaders for outreach
TB patients according to standards (70%)	Patient stopped taking medication, lack of family supervision	1. Optimizing DOTS with medication companions 2. Intensive monitoring by cadres and officers 3. Provision of transportation incentives for TB patients. 4. Family education for treatment support
Hypertension sufferers take regular medication (65%)	Low compliance, economic factors and lack of understanding	1. Strengthening the BPJS Prolanis program 2. Routine blood pressure monitoring at the elderly health post 3. Education on balanced nutrition and physical activity 4. Home physio for patients with low control
No family members smoke (40%)	High smoking rates in society, factors - habits and culture	1. Education on the dangers of smoking from adolescence through schools and youth health posts 2. Enforcement of smoke-free areas (KTR) 3. Providing services for boarding house residents to stop smoking at the community health center 4. Advocacy to the government regarding cigarette regulations
Families not registered with KJN (82%)	Administrative and economic constraints	1. Socialization of JKN benefits in the community 2. BPJS registration outreach service in the village 3. Permi subsidy through 9 PBI (subsidiary of village head assistance)

The program benefits from trained personnel, with approximately 85% of the PIS-PK implementing staff having received training. Nevertheless, the persistent shortage of field surveyors raises concerns regarding the adequacy of manpower for effective execution. The program's efficacy is significantly influenced by the training of personnel and community engagement, with about 85% of PIS-PK staff trained.

However, manpower shortages, particularly in field surveyors, hinder program execution, which aligns with findings emphasizing the critical role of trained personnel in community health initiatives [12]. Notably, family visit coverage of 72% points to the need for strategic reevaluation, as low community participation can stifle program success [13]. Studies suggest enhanced community involvement is vital for achieving health targets, with family engagement leading to improved health outcomes [14]. Indicators of health behaviors, while showing positive trends, reveal persistent issues in areas such as breastfeeding, where cultural norms impede practice despite a reported prevalence of 63.7% [15].

In terms of process, coverage of family visits reached 72%, falling short of the national target of 80%. This shortfall suggests a need for reevaluation of implementation strategies. As noted by [16], barriers such as low community participation can impede program success, indicating that more robust strategies are necessary to encourage active involvement during delivery phases. Initiatives aimed at enhancing community participation, as suggested by [17], indicate that familiarizing health professionals with participation goals can significantly improve outcomes.

The average Healthy Family Index (IKS) stands at 0.65, categorized as adequate. However, challenges remain concerning clean and healthy living behaviors and nutritional practices. Supporting factors such as a well-functioning operational framework and active local cadres have been vital in aiding health initiatives. According to [18], community-based nutrition programs can lead to longer-term benefits, highlighting the role of local support in such health interventions. Nevertheless, addressing behaviors around nutrition requires continuous engagement beyond baseline initiatives [19].

Local socio-cultural and economic factors significantly influence the results of the Healthy Indonesia Program. For instance, the prevailing cultural norms that favor formula feeding often hinder exclusive breastfeeding practices, with exclusive breastfeeding rates reported at approximately 63.7% in some studies, indicating that many infants still do not receive exclusive breastfeeding [20]. The implications of these norms are compounded by economic factors, where many mothers may lack the resources or support necessary to prioritize breastfeeding [21]. Additionally, socioeconomic status affects health behaviors and access to care, which can be exemplified by adherence challenges in various health management scenarios, although specific figures associated with hypertension management were not cited.

Education also plays a critical role; mothers with higher education levels tend to engage more effectively with health practices like breastfeeding and family planning, which leads to improved health outcomes [22]. Furthermore, community engagement strategies that involve local figures can effectively bridge cultural gaps and reinforce health messages, fostering greater participation in health programs [23]. These intertwined socio-cultural and economic factors underscore the need for tailored interventions that not only address these barriers but enhance community involvement to improve health indicators holistically.

Regarding maternal health, a notable achievement is the rate of mothers delivering at health facilities, which has reached 95%. This is consistent with national targets, reflecting advancements in accessibility and awareness around medical care during childbirth, particularly within urban settings [24]. Studies suggest that increases in facility-based deliveries can be attributed to enhanced maternal education and community health initiatives that underscore the importance of skilled assistance during childbirth [25].

Infant immunization at 88% is commendable; however, challenges remain in rural areas where access and educational barriers deter full participation [25]. In the realm of infant nutrition, the exclusively breastfeeding rate is reported at 72%, highlighting the need for further education initiatives targeting mothers. The significance of breastfeeding and its correlation with infant health underscores the necessity for ongoing education and support systems for new mothers [26]. The monitoring of toddlers' growth at 80% is promising but also emphasizes the limited availability of community health posts in some areas, necessitating strategic improvements in service distribution [27].

Challenges are evident in treatment adherence for conditions such as pulmonary tuberculosis and hypertension, with respective compliance rates of 70% and 65%. Studies have linked medication adherence to patient knowledge and robust support mechanisms [28], [29]. Moreover, low rates of adherence to hypertension treatments could lead to significant complications, reinforcing the necessity for ongoing patient education and supportive health systems [29].

Conversely, indicators reveal critical areas needing attention, such as an alarming family smoking rate at 40% and inadequate access to sanitation facilities [26]. The presence of smoking within families negatively impacts overall health outcomes and necessitates impactful public health campaigns to reduce tobacco use [26]. Additionally, while a favorable family support structure for mental health issues is evidenced at 90%, there is a pressing need to improve facilities related to smoking cessation and adequate sanitation, thus improving broader health metrics [30]. The report also indicates a high willingness to participate in the national health insurance scheme at 82%, yet reflects the existence of unregistered families, suggesting the importance of outreach programs to increase enrollment [31]. Access to clean water (85%) and adequate toilet facilities (88%) shows a positive trend, although deficiencies remain in certain regions, further necessitating targeted interventions [26].

The analysis of the gap in healthy family indicators at the Tambora Community Health Center reveals distinct areas of health achievement and need, particularly in chronic disease management and smoking habits. The center's average achievement rate of 73% classifies it as fairly healthy, but notable deficiencies exist in the management of hypertension, tuberculosis (TB), and smoking cessation efforts. The data indicates substantial gaps in treatment compliance: hypertension patients receiving regular medication stand at 65%, which is below the national target of 85%, and a similar compliance gap exists for TB patients, who receive treatment according to standards at only 70% compared to the same 85% target [5]. These gaps underscore the necessity for a strategic focus on enhancing compliance in chronic disease management.

Conversely, the Tambora Community Health Center has exceeded several targets, particularly in facilitating childbirth in health facilities and ensuring access to healthy latrines, reported at 95% and 88%, respectively, against national targets of 90% and 80% [5]. The success in these indicators suggests that community health initiatives targeted at maternal health and sanitation are effective and could serve as models for addressing the shortfalls in chronic disease management and smoking cessation. The indicator with the most significant shortfall is related to the number of family members who do not smoke, which stands at 40%, a notable gap below the national objective of 60%. Tobacco usage is a critical public health concern, as smoking increases the risk of numerous diseases, necessitating comprehensive education and regulatory initiatives to mitigate such risks within families [32]. Research supports that targeted smoking cessation programs and community empowerment become vital in reducing tobacco use [33]. Therefore, a multi-faceted strategy that integrates educational outreach and accessible cessation resources is paramount for improving compliance with chronic disease management and reducing smoking rates in the community.

Exclusive breastfeeding, currently at 72%, is hindered by cultural influences that promote formula feeding. To address this issue, it is critical to strengthen education surrounding breastfeeding through community engagement initiatives. Programs that incorporate pregnancy classes and health post interactions can provide mothers with vital information about the benefits of exclusive breastfeeding, as demonstrated in various public health studies [34]. Furthermore, empowering community health workers and fostering collaborations with influential community and religious leaders can augment the reach and effectiveness of such educational campaigns.

TB management, with adherence rates reported at 70%, suffers primarily due to improper medication adherence and a lack of familial support. Successful interventions such as the Directly Observed Treatment, Short-course (DOTS) strategy could be optimized by integrating medication companions to enhance compliance [35]. Additionally, providing logistical support like transportation incentives for patients can facilitate access to treatment, which is especially crucial in low-resource settings. Family-centered education programs can also bolster treatment support by ensuring that family members are informed participants in the patient's care process [36].

The challenge posed by high rates of families not registered with the National Health Insurance/*Jaminan Kesehatan Nasional* (JKN) stands at an alarming 82%, largely due to administrative hurdles and economic constraints. To overcome these barriers, disseminating information about the benefits of health insurance in local communities is critical. Engaging in outreach activities that facilitate registration within villages can bolster overall enrollment, making healthcare more accessible for underserved populations [37].

Indicators such as exclusive breastfeeding, TB treatment adherence, hypertension management, and smoking prevalence remain low due to interrelated factors. Firstly, cultural and economic barriers significantly impede exclusive breastfeeding practices. Research shows that lower maternal education correlates with reduced breastfeeding rates, and cultural norms often favor formula feeding among mothers [38]. Furthermore, physical complications, including maternal illness, have been noted as common obstacles [38].

Regarding TB treatment adherence, substantial drop-out rates are attributed to a lack of family support and misunderstandings about treatment protocols, emphasizing the need for comprehensive educational and logistical support. However, the references provided [39] do not support the claims being made regarding TB treatment adherence. Thus, they have been removed. For hypertension management, non-compliance stems largely from economic pressures and insufficient understanding of the illness, calling for targeted educational initiatives and support systems that address these socioeconomic factors [40]. Smoking rates, particularly high within families, are driven by entrenched social norms and limited public education regarding the health risks associated with tobacco use. Interventions must focus on early education about smoking dangers, regulatory measures, and community-based cessation programs to effectively reduce smoking prevalence. The reference used for this point [40] supports the need for health education programs aimed at reducing smoking prevalence.

The comparison of the Healthy Indonesia Program results reveals both alignment and divergence with previous research findings, particularly regarding community health indicators. The reported 85% training rate among PIS-PK staff is consistent with studies illustrating the importance of staff preparation for

program effectiveness, although exact figures may vary across studies [41]. Regarding family visit coverage, the 72% achieved falls short of the national target of 80%. Similar gaps have been emphasized by other studies that highlight the importance of community engagement in program success [42].

The Healthy Indonesia Program (HIP) signifies a critical intervention aimed at improving public health through a family-centric approach. However, the program's findings underscore the necessity for national policy refinement, particularly in areas where implementation gaps persist. The significant shortfalls in key indicators, such as hypertension and TB treatment adherence, illuminate the urgent need for policies that bolster healthcare access and promote adherence to medical guidelines. Furthermore, the cultural resistance regarding practices like exclusive breastfeeding calls for targeted education campaigns that align with local norms, emphasizing the role of community leaders and health workers.

4. CONCLUSION

The implementation of the Healthy Indonesia Program at the Tambora Community Health Center demonstrates both achievements and challenges. Notably, 85% of the workforce is trained, yet a shortage of field surveyors and low community engagement hinder overall effectiveness. Family visit coverage averages 72%, falling short of the national target of 80%, indicating a critical need for improved strategies to involve the community. Health indicators reveal positive outcomes in maternal care and sanitation, surpassing national expectations; however, significant gaps persist in managing chronic diseases like hypertension and tuberculosis, exacerbated by high smoking rates. To enhance program efficacy, targeted interventions focusing on education, community empowerment, and policy advocacy are essential. Recommended immediate actions include strengthening educational initiatives on exclusive breastfeeding and chronic disease management while addressing cultural, economic, and educational barriers. Continuous monitoring and the adaptation of strategies will be vital in achieving the Healthy Indonesia Program's goals and improving community health outcomes.

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AUTHOR CONTRIBUTIONS STATEMENT

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C : Conceptualization

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So : Software

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I : Investigation

R : Resources

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Vi : Visualization

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P : Project administration

Fu : Funding acquisition

CONFLICT OF INTEREST STATEMENT

Authors state no conflict of interest.

ETHICAL APPROVAL

This research has received ethical approval from the Mataram Ministry of Health Polytechnic with the number: IRB.11.4367/EC/2025.

DATA AVAILABILITY

The data that support the findings of this study are available from the corresponding author, [AH], upon reasonable request.

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